Useful Definitions
Rates and Risk Reserves Webcast
March 30, 2006

- Actuarially sound: Medicaid benefit plan premium rates are actuarially sound if, for business in the state for which the certification is being prepared and for the period covered by the certification, projected premiums, including expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows, and investment income, provide for all reasonable, appropriate and attainable costs, including health benefits, health benefit settlement expenses, marketing and administrative expenses, any state-mandated assessments and taxes, and the cost of capital.
  SOURCE: American Academy of Actuaries Practice Note, August, 2005.

- Actuaries: Certified professionals who assess the risk of certain events occurring and calculate business costs such as risk reserves, insurance premiums, and pension contributions to limit risk. The U.S. Department of Health and Human Services requires an actuary certify that any capitation rate provided to a managed care organization for the costs of serving Medicaid recipients is actuarially sound.

- Benefit Package: The set of services provided to a member enrolled in a managed care plan. This is a critical element in rate setting because the cost data that are used to develop the rate must match the services being provided by the managed care organization.

- Capitation: A single payment offered in exchange for a good or service, typically involving the transfer of risk from one party to the other.

- Casemix: The proportion of a population's members in two or more sub-populations. For example, Family Care's casemix of children and adults is 100% adult. Family Care's casemix of disabled individuals and frail elders is approximately 70% frail elders and 30% disabled individuals. Casemix is also used to describe the proportional characteristics of a population relative to another population. For example, a population covered under one MCO could be described as having a casemix with higher acuity than a population covered under another MCO, i.e. the proportion of individuals with high acuity is greater in one MCO than the other.

- CMO (= MCO): An acronym for *care management organization*, which can be used interchangeably with managed care organization. This is the organization that will receive funding from the state in the form of a capitation rate, manage the care of all enrolled members, and hold the risk for those members' service costs.

- CMS: An acronym for Centers for Medicare & Medicaid Services, the division within the U.S. Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.

- Cost Experience: Sometimes just called "experience." This is shorthand for the service costs that an MCO has incurred over a given period of time for an individual member, target group, or MCO as a whole.

- Encounter data: Cost and utilization data collected by the MCO, and provided to the state using standard reporting criteria, for each interaction between a managed care enrollee and a given provider. Information collected typically involves the member served, the date of service, the provider offering the service, the type of service, the cost of service, the number of units of service provided, etc. Data may then be used for utilization analysis and capitation rate development.

- IBNR: An acronym for "incurred but not reported." In a managed care setting, these are costs are associated with a service that has been provided, but these costs have not yet been paid by the managed care organization. These costs therefore represent an important liability to the managed care organization. The managed care organization must have established processes for estimating how large is this liability.

- PMPM: An acronym for "per member per month." This is the unit of analysis that is most often used in managed care programs and settings. Capitations amounts are typically discussed in these terms (e.g., "the State will pay the MCO $2,000 PMPM").

- Reinsurance: An insurance product that can be purchased by an MCO to reduce the level of risk that the MCO faces. By paying a monthly premium, the MCO can shift certain types of claims, or service costs, to the entity providing this service. Reinsurance may be attached to a specific service (e.g., high costs hospitalizations), to a particular person (e.g., very high cost outliers), or to an aggregate level of claims (i.e., service costs incurred by the entire enrolled population).

- Risk: The possibility that something harmful (e.g., a financial loss) may occur. In managed care settings, risk is typically associated with unanticipated costly events, such as a hospital stay, an emergency room visit, or a nursing home placement.

- Risk adjustment: The process used to account for groups of enrollees with different acuity levels. CMS requires risk adjustment be used in setting rates for voluntary managed care programs (Family Care currently is a voluntary managed care program). Risk adjustment provides additional funding in a capitation rate for enrollees with relatively higher acuity and less funding for enrollees with relatively lower acuity. Risk adjustment can also refer to a data analysis process. For example, one can *risk adjust* an analysis of outcomes, to control for groups with different levels of care needs.

- Risk reserve: A separately identifiable restricted investment reserve account that provides for the continuity of care for enrolled members, accountability to taxpayers, and effective program administration. These funds are not for the day-to-day management of the MCO's operations, but an MCO may need to rely on this fund in a year when there is a loss. Typically, if this occurs, a plan to replenish the fund would need to be created.

- Solvency protection: A series of administrative requirements that are intended to ensure the overall financial health of an MCO , i.e., guarantee that the MCO will remain solvent. Solvent is defined here as the ability to pay all legal debts. These administrative requirements may involve very different types of funds and activities, and they will typically be defined by the agency that has direct regulatory oversight of an organization. The solvency protection approach in Family Care, for example, is defined in contract by the Wisconsin DHFS and includes three different layers of protection that the MCO must meet.

- WPP: An acronym for the *Wisconsin Partnership Program*, one example of a fully integrated health and long-term care program for frail elderly and people with disabilities. The Partnership Program consists of several community-based organizations located in three different geographical regions of Wisconsin. The program is supported by a combination of Medicare and Medicaid funding. The goals of Partnership program are to: improve quality of health care and service delivery while containing costs; reduce fragmentation and inefficiency in the existing health care delivery system; and increase the ability of people to live in the community and participate in decisions regarding their own health care.

- Working capital: The liquid assets that are available for the day-to-day operations an MCO carries out, defined as current assets minus current liabilities.